

Indiana State Department of Health

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>013039</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING: _____  B. WING: _____	(X3) DATE SURVEY COMPLETED  <b>12/28/2016</b>
NAME OF PROVIDER OR SUPPLIER  <b>ALLISONVILLE MEADOWS ASSISTED LIVING</b>		STREET ADDRESS, CITY, STATE, ZIP CODE <b>10410 ALLISONVILLE ROAD FISHERS, IN 46038</b>		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
R 000	<p><b>INITIAL COMMENTS</b></p> <p>This visit was for a State Residential Licensure Survey.</p> <p>Survey dates: December 27 and 28, 2016</p> <p>Facility number: 013039 Provider number: N/A AIM number: N/A</p> <p>Residential Census: 120</p> <p>Sample: 11</p> <p>Allisonville Meadows Assisted Living was found to be in compliance with 410 IAC 16.2-5 in regard to the State Residential Licensure Survey.</p> <p>Quality review completed by 30576 on January 3, 2017.</p>	R 000		

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LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE